1.5 PAYMENT PROCESS

Payments to ICF/MR providers for services rendered will be made monthly based on the appropriate billing claim submitted by the provider at the established interim per diem rate. These interim rate payments and payments generated by subsequent rate adjustments to the interim and final rate will be processed by the Division of Medical Assistance and Health Services.

1.6 RECORDKEEPING

Providers of care under the ICF/MR program are required to maintain detailed records supporting expenditures incurred for services provided to recipients of ICF/MR care. The records of the facility must be auditable and capable of substantiating tests of reasonableness for each specific item of cost.

A newly participating provider of services shall make available to the Department for examination its fiscal and other records for the purpose of determining such provider's ongoing recordkeeping capability and inform the Department of the date its initial cost reporting period will end (fiscal year). This examination is intended to assure that (1) the provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes, and (2) no financial arrangements exist that will thwart the commitment of the ICF/MR program to reimburse providers the reasonable cost of services furnished beneficiaries. The data and information to be examined includes cost, revenue, statistical and other information pertinent to reimbursement.

The provider shall furnish such information to the Department as may be necessary (i) to assure proper payment by the program, including the extent to which there is any common ownership or control between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports, (ii) to receive program payments, and (iii) to satisfy program overpayment determinations.

The provider shall permit the Department to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall include, but not be limited to, matters of provider ownership, organization, and operation; fiscal, medical, and other recordkeeping systems; Federal income tax status; asset acquisition, lease, sale, or other action; franchise or management arrangements; patient service charge schedules; matters pertaining to costs of operations; amounts of income received by source and purpose; and flow of funds and working capital.

The provider, when requested, shall furnish the Department copies of patient service charge schedules and changes thereto as they are put into effect. The Department shall evaluate such charge schedules to determine the extent to which they may be used for determining program payment.

1.7 SUSPENSION OF PAYMENTS TO PROVIDER

When the Department determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the ICF/MR program, payments to such provider shall be suspended until the Department is assured that adequate records are maintained. Before suspending payments to a provider, the Department shall send written notice to such provider of its intent to recommend suspension of payments. The notice shall explain the basis for the Department's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies. The provider will be given the opportunity to submit a statement (including any pertinent evidence) as to why the suspension should not be put into effect.

The Bureau of Rate Setting may request the Director, Division of Medical Assistance and Health Services, to suspend payment to a provider for failure to submit required reports.

1.8 APPEALS PROCESS

Where and ICF/MR provider believes that owing to an unusual situation, the application of these guidelines results in an inequity, the ICF/MR provider may appeal the rate component(s) affected by the unusual situation(s). All appeals must be submitted in writing to the Director, Division of Medical Assistance and Health Services, within thirty (30) days of the rate modification. Two levels of appeals are available to the ICF/MR providers.

Level I - The first level of appeal represents an informal administrative process and can include two (2) stages. The first stage of a Level I appeal will be heard by the Director of Finance, Department of Human Services. The ICF/MR provider should be prepared to present such substantiating material as may be required for an informal discussion of the subject matter. This level of appeal will attempt to reach equitable resolutions of matters peculiar to individual ICF/MR providers. It will not be expected to resolve items which have policy implications or broader applicability. A recommendation will then be forwarded to the Director, Division of Medical Assistance and Health Services, for his approval.

If the ICF/MR provider is not satisfied with the results of the first stage of the Level I appeal, a second stage appeal may be requested. The second stage appeal will be heard by a panel of designated representatives from the Division of Medical Assistance and Health Services and the Department of Human Services. This panel will be chaired by a senior panel member from the Division of Medical Assistance and Health Services. The Director, Division of Medical Assistance and Health Services, will schedule an appropriate time and place for the aforementioned panel to hear the provider's appeal. The panel will record and submit its recommendations to the Director, Division of Medical Assistance and Health Services, for final resolution.

Level II - If the ICF/MR provider is still not satisfied with the results of the Level I appeal, the contested rate issues will be referred to the Office of Administrative Law for a formal hearing, pursuant to the Administrative Procedure Act.

Professional fees related to legal actions against the State are nonallowable costs to the ICF/MR program.

Adjustments resulting from the appeals will be effective:

- The beginning of the reimbursement period if an error in computation was made by the Department, or if the appeal was submitted within the specified period.
- The first of the month following the date of appeal for non-computational matters, if the appeal is submitted after the specified period.

The date of submission is defined as the date received by the Department.

1.9 ICF/MR PROVIDER AGREEMENT

The Department of Human Services will not make payments to a provider for ICF/MR services without the benefit of a formal provider agreement.

The effective date of the provider agreement will not be earlier than the date of certification. The provider agreement will be written in accordance with the provisions of certification made by the New Jersey Department of Health. The Department of Human Services may refuse to execute a provider agreement or may cancel a provider agreement for good cause.

1.10 CERTIFICATION OF ICF's/MR

The ICF/MR provider must obtain a notice of facility certification, from the New Jersey Department of Health prior to entering into a provider agreement with the Department, to render ICF/MR services. To obtain the notice of facility certification, the provider must satisfy 1) State licensing standards which include Safety and Sanitation standards, and 2) Federal standards for program and staffing of ICF/MR facilities.

SECTION 2 - COST FINDING METHODOLOGY

SECTION 2
COST FINDING METHODOLOGY

2.1 General

2.2 Adequate Cost Data

2.3 Cost Finding Method

Statistical Bases to be Used
Table - Cost Distribution Bases

2.1 GENERAL

The Department engages the services of both public and private providers for participation in the ICF/MR program. The Bureau of Rate Setting is responsible for establishing a system which effectively provides for the determination of reasonable cost-related per diem rates for the services rendered by providers to its recipients. The Medicare principles of reimbursement (42 CFR Part 413) are the basis for the determination of these per diem rates.

The Medicare principles of reimbursement are to be applied on behalf of the ICF/MR program to public and private organizations. In consideration of the wide variations in size and scope of services of providers and regional differences that exist, the principles are flexible on many points.

An important role of the Bureau of Rate Setting is to furnish consultative services to providers in development of accounting and cost-finding procedures which will assure them equitable payment under the ICF/MR program.

In formulating methods for making fair and equitable reimbursement for services rendered to recipients of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional costs that is borne by the program is related to the care furnished recipients so that no part of their cost would need to be borne by other patients. Conversely, cost attributable to other patients of the institution are not to be borne by the ICF/MR program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to recipients as such costs vary from institution to institution.

Putting these several points together, certain tests have evolved for the principles of reimbursement and certain goals have been established. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the recipients of this program and other patients of the provider that takes account of the actual use of services by the recipients of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of public, non-profit, and profit-making organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.